

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009411

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 15 1962

500

585

VS 300  
Rev. 4/59

14000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <del>St. Louis</del>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SKYLINE Koch</b>		Length of stay in 1b <b>4 days</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R. Koch Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4632 Bircher Blvd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>M.</b> Last <b>Schuermann</b>		4. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet metal worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	9. AGE (last birthday) <b>42</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME <b>David Schuermann</b>		11b. MOTHER'S MAIDEN NAME <b>Laura Vornburg</b>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> If yes, give war or dates of service <b>37051980 WW2</b>		13. INFORMANT <b>R. Koch Hospital Koch, Mo.</b> Address	
14. CAUSE OF DEATH (Enter only one cause per line. If death was caused by: PART I. IMMEDIATE CAUSE (a) <b>tuberculosis bronchopneumonia</b> DUE TO (b) <b>sepsis</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>2-13-62</b> to <b>2-18-62</b> and last saw her alive on <b>2-18-62</b> Death occurred at <b>2-18-62</b> <b>7.30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated:			
22a. SIGNATURE (Degree or title) <b>Bernard Friedman, M.D.</b>		22b. ADDRESS <b>Koch Hospital, Koch Mo.</b>	
22c. DATE SIGNED <b>2-18-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2-21-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>
24. FUNERAL DIRECTOR <b>Edw Koch &amp; Son 3516 N. 14th</b>		25. DATE RECD. BY LOCAL REG. <b>2-19-62</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.